Department of Human Resources
Division of Health Care Financing & Policy
Meeting for Public Comment on Review
Of Nevada Medicaid Services Manual and
Medicaid Operations Manual
April 20, 2005

Minutes

Attendees:

In Carson City, NV:
Charles Duarte, Administrator, DHCFP
John Liveratti, Chief, DHCFP, Compliance
Darrell Faircloth, DAG
Eric King, DHCFP, Rates
Others in attendance shown on attached lists.

In Las Vegas, NV:
Marcie French, DHCFP

The meeting was called to order by John Liveratti, Chief of Compliance at 9:00am in the conference room of the Public Utilities Commission at 1150 East Williams Street in Carson City, Nevada. The meeting was aired by video-conference to Las Vegas simultaneously. Those in attendance are on the attached lists from both locations.

I. Discussion and Proposed Adoption of Amendments to MSM Chapter 1200 – Prescribed Drugs

Coleen Lawrence, Chief of Program Services, introduced amendments to MSM Chapter 1200 - Prescribed Drugs. This chapter is being updated to add the clinical indications approved by the Drug Use Review Board in September 2004. Under reimbursement, the methodology for compound medications is being changed to support NCPDP 5.1 Multi-ingredient functionality. There is also clarification of billable services under Long Term Care.

The following updates are to be made: Under Definitions, the definitions of Legend Drugs have been moved from one section to another, nothing has changed in the definition. Moved and clarified the definition of Non-Legend Drugs. Added the definition of Single Source Drugs. Under 1203.1.A.b policy there has been grammatical clean-up from “Department” to “Division” and for the correct spelling of immunizations. Under 1203.1D4 there was an amendment to the definitions of Compound Drugs to be consistent with NCPDP. Under 1206.A amended the definition and clarified for the use of multi-ingredient and functionality. There was also an amendment and clarification to the definition for Supplies under 1206.C. In 1206. D there was a grammatical change within Long Term Care definition and title. In 1206.D.1 under Long Term Care there was clarification of the Non-Billable items under a Long Term Care facility for pharmacy, also clarified the Billable items under 1206.D.2.

The following changes have been recommended into Chapter 1200 due to the Drug Use Review Board in September 2004: In Appendix A.B.1 changed “Oxycontin” policy to “Long-Acting Narcotics” policy. Also, amended the duration for the proton pump inhibitors. Under CNS Stimulants, changed it from “CNS Stimulants” to “Agents for the treatment of ADHD. “ Again, there was a clarification of verbiage from “Department” to “Division”. Under Appendix A.7.a Levitra has been added as an erectile dysfunction medication. Under Appendix A.B.1.a. Coverage and Limitations, additional indications for specific medications have been added.

Over the last few weeks, with the legislative hearings, SB260 proposed the addition of the definition of Step Therapy to the pharmacy chapter. It will be under the Definitions section of Chapter 1200 for Step Therapy and should satisfy the intent of SB260.

Pat Coward, on behalf of Pharma (the manufacturing industry), introduced and read in the friendly amendment of the definition of Step Therapy: Step Therapy is the process of beginning drug therapy for a medical condition with the safest and most effective lower risk drug therapy and progressing to other drug regimens only if medically necessary. Step Therapy protocols are developed at a therapeutic class level, and approved through the Drug Use Review Board based upon clinical evidence or best clinical practice guidelines. Step Therapy guidelines may be implemented through a prior authorization process, prospective Drug Use Review edits, and/or provider educational programs.

Mr. Liveratti invited public comment on this issue. There were no comments from Carson City or Las Vegas.

Mr. Liveratti closed the public hearing on MSM Chapter 1200 and moved acceptance and approval of the changes.

Mr. Duarte accepted the changes to MSM Chapter 1200 subject to a final spelling and grammar check.

II. Discussion and Proposed Adoption of New MSM Chapter 700 – Medicaid Rates Appeal

John Macnab, MA IV, Rates Unit, introduced the proposed adoption of the new MSM Chapter 700 – Medicaid Rates Appeal. This chapter formalizes a rate appeal process which the division has been using informally. The chapter determines and requires what needs to be submitted by a provider that wishes to file a rate appeal, what the Division will look at, what information the Division will consider as supporting evidence from the provider to grant the rate appeal. It also clarifies the time period requirements.

Mr. Duarte asked Mr. Macnab if this addresses the specific sub-components and if those can be appealed or should be mentioned in any appeal of a rate.

Mr. Macnab responded that typically the provider would give DHCFP the information anyway when they are looking at a rate appeal.

Eric King, Chief of Rates and Cost Containment, added that there are provisions further in the chapter requiring the provider to supply additional information if the provider hasn't given enough information in their initial appeal.

Mr. Duarte responded that in the past a specific section of the rate was appealed, the entire rate usually wasn't appealed. Again, he said, it was more for the provider to identify to us what specifically their concern was. He stated that we know we don't pay enough money, but we need to know what part of the rate is specifically being appealed, i.e. Direct Care, In-Direct Care, Administrative, Room & Board.

Mr. Duarte asked Mr. Liveratti and Mr. Faircloth what the process would be to add some language to clarify this issue.

Mr. Liveratti responded that we could adopt the chapter and direct staff to revise this section and bring it back for approval and that would be better than having no chapter at all.

Darrell Faircloth, DAG, indicated that he didn't think it would be a significant change to the chapter and he agreed with Mr. Liveratti to go ahead and adopt what has been presented and make the change later.

Mr. Liveratti invited public comment on this issue.

Charles Perry, Las Vegas attendee, asked Mr. Duarte if he could be quoted on his remark about Medicaid just not paying enough money.

Mr. Duarte agreed to the request.

Mr. Liveratti closed the public hearing on Chapter 700 and moved acceptance and approval of the changes and will direct staff to take this section under advisement and work on it.

Mr. Duarte accepted the changes to Chapter 700 as presented with the understanding that staff will go back and add more specific language to section 700.B.2 and is also subject to a final spelling and grammar check.

Mr. Liveratti stated for clarification that this correction in Chapter 700 will be brought back to a new public hearing once it has gone through the clearance process.

III. Discussion and Proposed Adoption of Amendments to the State Plan for Medicaid Services.

Mr. Liveratti opened up the public hearing for Discussion and Proposed Adoption of Amendments to the State Plan for Medicaid Services. He clarified that approval of State Plan does not take place at public hearings, comments are taken as a requirement of the Code of Federal Regulations. Public hearings must be conducted on state plan amendments that will have fiscal impacts to providers, the state, and the feds. This is an opportunity for comments about proposed state plan amendments and those comments may or may not be included in the state plan. The state plan is then sent to the Director's Office for approval and then to CMS for adoption.

Eric King, Chief of Rates and Cost Containment, introduced an amendment to Attachment 4.19 of the State Plan for Medicaid Services for Targeted Case Management services. This amendment is being proposed to clarify current provider reimbursement methodology, add private provider reimbursement methodology, and remove payment methodology that is currently contained in Attachment 3.1.A into 4.19.b. There are four sections in 3.1.a with payment methodology, this will be removed because typically the payment methodology belongs in 4.19.b.

Mr. Liveratti asked what the change is besides the move from one section to the other.

Mr. King responded that they are adding payment methodology for private providers, essentially using a market basket approach for those providers. That approach uses five elements: State of Nevada Personal Compensation Schedules, Employee Related Expense Factor, Productivity Assumptions, Average Supervisory Costs per Hour, and Administrative Overhead Rate. The current proposed rate is $55.03/hour which equates to $13.76/quarter hour rate for the provision of TCM services to qualified individuals.

Mr. Duarte confirmed with Mr. King that we are not proposing to put in the specific rate, but rather are adopting the methodology within the State Plan.

Mr. Duarte asked Mr. King if we provide the federal fiscal impact as part of the hearing.

Mr. King responded that it is on the agenda and will also be submitted to the Director's Office and CMS.

Mr. Liveratti asked for comments or questions.

There were no comments or questions from Las Vegas.

Michael Howie, from University of Nevada School of Medicine Practice Plan, spoke in regards to the proposed amendment about Targeted Case Management being provided by state agencies, and affiliates of the University of Nevada School of Medicine. He indicated that the School of Medicine has undergone some significant structural changes and formed the Integrated Clinical Services Board, which is made up of all state employees and completely controls all of the entities under the Practice Plan. All of the assets and liabilities of the entities are controlled by the Board of Regents and all of the employees underneath the Integrated Clinical Services Board, are either state employees or are directly supervised by state employees. The Board is made up of the Vice President of Administration & Finance for UNR, the Dean of the School of Medicine, two clinical faculty for north and south, and a sundry of people employed by the school. He stated the University of Nevada School of Medicine would like entities under the University of Nevada Practice Plan (specifically Integrated Clinical Services) to be considered public entities for the sake of rates and provider numbers.

Mr. Duarte responded that he spoke with Dean McDonald and his understanding was that the faculty practice plans were still separate 501C3's.

Mr. Howie indicated that they come under the umbrella of the Integrated Clinical Services, which is completely controlled by the University of Nevada system, the Board of Regents, Chancellor, President and all members are state employees. They have no employees, they are being kept as cost centers, they are subsidiaries. Mr. Howie clarified that in the current State Plan it states "affiliates of the University of Nevada", and that these entities actually become much more than affiliates, they are completely controlled by the state.

Mr. Duarte asked Mr. Howie who DHCFP can contact regarding the legal structure and how it operates.

Mr. Howie responded that Dean McDonald would be the contact and that he would most likely have the School of Medicine and University of Nevada's legal counsel assist.

Mr. Liveratti asked for any other comments or questions.

Jim Parcells, Chief Operating Officer of Mojave Adult, Child, and Family Services, responded that he wanted to comment on the market basket approach of rate setting. He then read Attachment A to the committee as his testimony.

Mr. Duarte thanked Mr. Parcells and Mr. Howie for their testimonies and asked if their intentions are to be recognized as state agencies or to change the methodology.

Mr. Howie responded that it is their intention to stay open, it is University of Nevada School of Medicine's intention to be recognized as a state agency since they are completely controlled by a public entity.

Mr. Parcells responded that it is Mojave Adult, Child, and Family Services intention to be considered a public entity, but, if they are not that he would like to see the Targeted Case Management methodology to be realistic for the provision of services to the clients.

Mr. Duarte asked Mr. King about the different methodologies possible for presentation besides the market basket approach that was used in the State Plan Draft.

Mr. King responded that AB513 (the Rates Task Force) had recommended possibly a negotiated rate. There is also the opportunity to cost settle.

Mr. Duarte asked if the cost documentation that Mr. Parcells provided was used in the rate evaluation.

Mr. King indicated that they attempted to and that the testimony that was given today provided more information than the original cost worksheet that was evaluated.

Mr. Duarte thanked everyone for their testimony and reiterated that this is just in preparation for submittal of a State Plan. The State Plan may or may not be submitted in the form that you see it today and the opportunity for a public hearing was afforded. He will go back and take a look at the written testimony of Mr. Parcells as well as the documentation that was previously provided. Mr. Duarte also said he would follow-up with Dean McDonald regarding the legal structures associated with the Integrated Clinical Services Board.

Mr. Liveratti asked for any other comments or questions. There were no comments from Las Vegas or Carson City.

Mr. Liveratti closed the public hearing on the State Plan Amendment.

The agenda completed, Mr. Liveratti adjourned the public hearing at 9:43am.